Must be received by the Benefits Department within 31 days of the qualifying event. MS1022.

Press Tab to begin filling out the form.

LOVELACE

SF 4400-LOD # (11-96)

LOVELACE HEALTH PLAN DISENROLLMENT FORM

When disenrolling employee please complete 1 and 2.
When disenrolling dependent(s) please complete 1, 3, and 4.

1.

Last Name	First Name	Initial	Social Security #
Mailing Address			Telephone Numbers Work
City	State	Zip	Home
HMO Subscriber #	Group #		DOB

2. PRIMARY REASON FOR EMPLOYEE DISENROLLMENT

- ☐ Terminated Employment
- ☐ Moved From Service Area
- ☐ Interagency Transfer
- ☐ Lost Eligibility
- ☐ Leave Status
- ☐ Lay Off
- ☐ Self Cancel
- ☐ Non-Payment Premium
- ☐ Premium Too High
- ☐ Deceased
- ☐ Dissatisfied With Plan
- ☐ Never Eligible
- ☐ Switched to Spouse's LHP Plan
- ☐ Switched to Other Insurance (Please Explain): _____
- ☐ Other (please explain): _____

Effective Date of Termination: Month _____ Day _____ Year _____

COMPLETE THIS SECTION WHEN DISENROLLING DEPENDENTS ONLY

FAMILY DEPENDENTS

3.

Last Name	First	Initial	DOB	Last Name	First	Initial	DOB
Spouse				Children			
Children							

4. REASON FOR DEPENDENT DISENROLLMENT

- ☐ Marriage
- ☐ Moved From Service Area
- ☐ Deceased
- ☐ Attained Limiting Age
- ☐ Lost Student Status
- ☐ Not Eligible
- ☐ Divorce
- ☐ Other (please explain): _____

Effective Date of Termination: Month _____ Day _____ Year _____

WE ARE SORRY TO LOSE YOU!

We appreciate you taking the time to provide us with the above information - it may indicate areas where improvement is needed. LHP offers a conversion plan to members who disenroll. If you wish to convert your coverage, you must notify LHP within thirty-one (31) days from the date of termination. If you are on Medicare, you may be eligible for conversion to the Lovelace Senior Options Plan. If you wish to convert, you must notify LHP within thirty-one days.

Employer's Signature _____ Subscriber's Signature _____ Date _____

Distribution: Original - LHP; First Copy - Employer; Second Copy - Employee

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